CHAMPVA POLICY MANUAL

CHAPTER 3
SECTION 5.9
TITLE: SURGERY REIMBURSEMENT

AUTHORITY: 38 USC 1713; 38 CFR 17.270(a) and 38 CFR 17.272(a)(b)

RELATED AUTHORITY: 32 CFR 199.4(c)(2)(I), (c)(2)(ii), (c)(2)(iii) and 32 CFR 199.14(h)(ix)

TRICARE POLICY MANUAL: Chapter 13, Section 2.5, 3.7 and 3.7A

I. EFFECTIVE DATE(S)

August 26 1985 for surgery

April 5 1989 for assistant surgeons

July 9 1990 for physician assistants

II. DEFINITIONS

A. Surgery is defined as medically appropriate operative procedures, including related preoperative and postoperative care. [32 CFR 199.4(c)(2)(i)].

B. A surgeon is a physician, dentist or podiatrist, acting within the scope of their license, who is the primary provider in the performance of a covered surgical service.

C. An assistant surgeon is a physician, dentist, podiatrist, certified physician assistant, or certified midwife acting within the scope of their license, who actively assists the operating surgeon in the performance of a covered surgical service.

D. A physician assistant (assistant-at-surgery) is one who actively assists the operating surgeon with an authorized surgical procedure. [32 CFR 199.14(h)]

E. Incidental procedure. An incidental procedure is performed at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources, and/or is clinically integral to the performance of the primary procedure.

F. Allowable charge. The term "allowable charge" is the maximum amount CHAMPVA will authorize for professional services of physicians and other individual professional providers (including professional services rendered by these providers in hospitals) and for certain other services provided incidental to the professional services

(see Chapter 3, Section 5.1, *Outpatient and Inpatient Professional Provider Reimbursement)*.

III. POLICY

A. Multiple Surgery.

1. When multiple surgical procedures are performed during the same operative session, benefits shall be limited to the lesser of the total billed charge or the sum of 100 percent of the allowable charge for the major surgical procedure and 50 percent of the allowable charge for the other procedures. The major procedure is that procedure for which the allowable charge is greatest.

2. If multiple surgical procedures involve the fingers or toes, benefits for the first surgical procedure shall be at one hundred (100%) percent of the allowable charge; the second procedure at fifty (50%) percent; and the third and subsequent procedures at twenty-five (25%) percent. [32 CFR 199.4(c)]

B. Multiple Primary Surgeons. When more than one surgeon acts as a primary surgeon for multiple procedures during the same operative session, the services of each may be covered.

C. Pre-operative care. Pre-operative care (e.g., history and physical), rendered in a hospital specifically for the surgery, is normally included in the global surgery charge. This also applies to routine examinations in the surgeon's office where such examination is performed to assess the beneficiary's suitability for the subsequent surgery.

D. Post-operative care. All services provided by the surgeon or assistant surgeon for post-operative complications (e.g., replacing sutures, servicing infected wounds) are included in the surgical package if they do not require additional trips to the operating room. All visits with the primary or assistant surgeon during the 90-day period following major surgery are included in the surgical package except for a problem(s) unrelated to the diagnosis for which surgery was performed.

Note: For example, if after surgery for cancer, the physician who performed the surgery subsequently administers chemotherapy services, these services would not be considered as part of the global surgery package.

E. Re-operations for complications. All medically necessary return trips to the operating room, for any reason and without regard to fault, are covered.

F. Billing for major surgical procedures. Physicians who perform the entire global surgical package, which includes the pre- and post-operative care as well as the surgery, must bill for their services with the appropriate CPT code. Separate billings for visits or other services should not be submitted, as these services are considered all-

inclusive of the surgical package. The pre-operative period is the first day immediately before the day of surgery. The post-operative period is the 90 days immediately following the day of surgery. If the patient is returned to surgery for complications on another day, the post-operative period is 90 days immediately after the last operation.

G. Assistant Surgeons.

1. Services of an assistant surgeon are payable when:

(a) The surgical procedure is of such complexity and seriousness as to warrant an assistant surgeon. The assistant surgeon's services must be of the type that cannot be accomplished by operating room nurses or other such support staff of an operating room.

(b) The operating surgeon has certified that interns, residents or other hospital staff is not available to provide the surgical assistance.

2. When a procedure is submitted with an assistant surgeon modifier (80, 81, or 82), claim review software (artificial intelligence (AI)) determines whether that procedure always, sometimes, or never requires an assistant surgeon. If the determination is always, the modified code will pay, if the determination is never, the modified code will reject, if the determination is sometimes, medical review of the procedure is necessary.

3. The allowable charge for an assistant surgeon (where such services are covered) will be the lower of the billed charge or sixteen (16%) percent of the prevailing charge for the surgery performed. When an assistant surgeon is involved in multiple surgery, the same procedures for determining reimbursement for the primary surgeon (see paragraph A.) will be used in determining reimbursement for assistant surgeons.

H. Certified Physician Assistants (PA).

1. The allowable charge for PA services other than assistant-at-surgery may not exceed 85 percent of the allowable charge for a comparable service rendered by a physician performing the service in a similar location. [32 CFR 199.14(h)]

2. The allowable charge for PA services performed as an assistant-at-surgery may not exceed 65 percent of the allowable charge for a physician serving as an assistant surgeon, which is currently 16% of the allowable charge. [32 CFR 199.14(h)]

3. The procedure or services performed by the PA must be billed by the employing physician and identified as a separate line item (e.g., PA office visit).

I. Second and Third Opinion.

1. Claims for patient-initiated, second-physician opinions pertaining to the medical need for surgery, may be paid. Payment may be made for the history and examination of the patient as well as any other covered diagnostic services required in order for the physician to properly evaluate the patient's condition and render a professional opinion on the medical need for surgery.

2. In the event that the recommendations of the first and second physician differ regarding the medical need for such surgery, a claim for a patient-initiated opinion from a third physician is also reimbursable. Such claims are payable even though the beneficiary has the surgery performed against the recommendation of the second or third physician.

IV. POLICY CONSIDERATIONS

A co-existing illness, condition, or other complicating situation may necessitate the service of an assistant surgeon for a procedure that is generally not considered complex or serious enough to warrant an assistant. Such claims must be reviewed on a case-by-case basis in order to determine medical necessity.

V. EXCLUSIONS

A. Regardless of the complexity or seriousness of the procedure, benefits are not allowed for standby assistant surgeons who do not provide an active service (see Chapter 2, Section 13.10, *Standby Charges*).

B. Incidental procedures should not be billed for or reimbursed separately.

C. Services provided by medical students.

END OF POLICY